Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-9-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.

Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options

Y - Yes
N - No
U - Unknown
W – Clinically undetermined
Unreported/Not used – (Exempt from POA reporting)

Reporting Definitions

Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission
W = provider is unable to clinically determine whether condition was present on admission or not

Assigning the POA Indicator

Condition is on the "Exempt from Reporting " list

Leave the "present on admission" field blank if the condition is on the list of ICD-9-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for any condition the provider explicitly documents as being present on admission.

Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission

Assign "Y" for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign "Y" for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign "U" when the medical record documentation is unclear as to whether the condition was present on admission. "U" should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.

Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign "W" when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

Chronic condition with acute exacerbation during the admission

If the code is a combination code that identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to combination codes.

If the combination code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of CHF), assign "Y."

Conditions documented as possible, probable, suspected, or rule out at the time of discharge

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was suspected at the time of inpatient admission, assign "Y."

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on symptoms or clinical findings that were not present on admission, assign "N".

Conditions documented as impending or threatened at the time of discharge

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign "Y".

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were **not** present on admission, assign "N".

Acute and Chronic Conditions

Assign "Y" for acute conditions that are present at time of admission and N for acute conditions that are not present at time of admission.

Assign “Y” for chronic conditions, even though the condition may not be diagnosed until after admission.

If a single code identifies both an acute and chronic condition, see the POA guidelines for combination codes.

Combination Codes

Assign “N” if any part of the combination code was not present on admission (e.g., obstructive chronic bronchitis with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission)

Assign “Y” if all parts of the combination code were present on admission (e.g., patient with diabetic nephropathy is admitted with uncontrolled diabetes)

If the final diagnosis includes comparative or contrasting diagnoses, and both were present, or suspected, at the time of admission, assign “Y”.

For infection codes that include the causal organism, assign “Y” if the infection (or signs of the infection) was present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents pseudomonas as the causal organism a few days later).

Obstetrical conditions

Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or obstetrical condition described by the code was present at the time of admission or not.

If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign “Y”.

If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign “N”.

If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign “N”.

(e.g., Code 642.7, Pre-eclampsia or eclampsia superimposed on pre-existing hypertension).

If the obstetrical code includes information that is not a diagnosis, do not consider that information in the POA determination.

(e.g. Code 652.1x, Breech or other malpresentation successfully converted to cephalic presentation should be reported as present on admission if the fetus was breech on admission but was converted to cephalic presentation after admission (since the conversion to cephalic presentation does not represent a diagnosis, the fact that the conversion occurred after admission has no bearing on the POA determination).

Perinatal conditions

Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y". This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal).

Congenital conditions and anomalies

Assign "Y" for congenital conditions and anomalies. Congenital conditions are always considered present on admission.

External cause of injury codes

Assign "Y" for any E code representing an external cause of injury or poisoning that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)

Assign "N" for any E code representing an external cause of injury or poisoning that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission)

Codes and Categories EXEMPT
from "Diagnosis Present on Admission" Requirement

Note: "Diagnosis present on admission" for these code categories are exempt because they represent circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission

137-139, Late effects of infectious and parasitic diseases
268.1, Rickets, late effect
326, Late effects of intracranial abscess or pyogenic infection
438, Late effects of cerebrovascular disease
650, Normal delivery
660.7, Failed forceps or vacuum extractor, unspecified
677, Late effect of complication of pregnancy, childbirth, and the puerperium
905-909, Late effects of injuries, poisonings, toxic effects, and other external causes
V02, Carrier or suspected carrier of infectious diseases
V03, Need for prophylactic vaccination and inoculation against bacterial diseases
V04, Need for prophylactic vaccination and inoculation against certain viral diseases
V05, Need for other prophylactic vaccination and inoculation against single diseases
V06, Need for prophylactic vaccination and inoculation against combinations of diseases
V07, Need for isolation and other prophylactic measures
V10, Personal history of malignant neoplasm
V11, Personal history of mental disorder
V12, Personal history of certain other diseases
V13, Personal history of other diseases
V14, Personal history of allergy to medicinal agents
V15, Other personal history presenting hazards to health
V16, Family history of malignant neoplasm
V17, Family history of certain chronic disabling diseases
V18, Family history of certain other specific conditions
V19, Family history of other conditions
V20, Health supervision of infant or child
V21, Constitutional states in development
V22, Normal pregnancy
V23, Supervision of high-risk pregnancy
V24, Postpartum care and examination
V25, Encounter for contraceptive management
V26, Procreative management
V27, Outcome of delivery
V28, Antenatal screening
V29, Observation and evaluation of newborns for suspected condition not found
V30-V39, Liveborn infants according to type of birth
V42, Organ or tissue replaced by transplant
V43, Organ or tissue replaced by other means
V44, Artificial opening status
V45, Other postprocedural states

V46, Other dependence on machines
V49.60-V49.77, Upper and lower limb amputation status
V49.81-V49.84, Other specified conditions influencing health status
V50, Elective surgery for purposes other than remedying health states
V51, Aftercare involving the use of plastic surgery
V52, Fitting and adjustment of prosthetic device and implant
V53, Fitting and adjustment of other device
V54, Other orthopedic aftercare
V55, Attention to artificial openings
V56, Encounter for dialysis and dialysis catheter care
V57, Care involving use of rehabilitation procedures
V58, Encounter for other and unspecified procedures and aftercare
V59, Donors
V60, Housing, household, and economic circumstances
V61, Other family circumstances
V62, Other psychosocial circumstances
V64, Persons encountering health services for specific procedures, not carried out
V65, Other persons seeking consultation
V66, Convalescence and palliative care
V67, Follow-up examination
V68, Encounters for administrative purposes
V69, Problems related to lifestyle
V70, General medical examination
V71, Observation and evaluation for suspected condition not found
V72, Special investigations and examinations
V73, Special screening examination for viral and chlamydial diseases
V74, Special screening examination for bacterial and spirochetal diseases
V75, Special screening examination for other infectious diseases
V76, Special screening for malignant neoplasms
V77, Special screening for endocrine, nutritional, metabolic, and immunity disorders
V78, Special screening for disorders of blood and blood-forming organs
V79, Special screening for mental disorders and developmental handicaps
V80, Special screening for neurological, eye, and ear diseases
V81, Special screening for cardiovascular, respiratory, and genitourinary diseases
V82, Special screening for other conditions
V83, Genetic carrier status
V84, Genetic susceptibility to disease
V85 Body Mass Index
V86 Estrogen receptor status

E800-E807, Railway accidents
E810-E819, Motor vehicle traffic accidents
E820-E825, Motor vehicle nontraffic accidents
E826-E829, Other road vehicle accidents
E830-E838, Water transport accidents
E840-E845, Air and space transport accidents

E846-E848, Vehicle accidents not elsewhere classifiable
E849.0-E849.6, Place of occurrence
E849.8-E849.9, Place of occurrence
E883.1, Accidental fall into well
E883.2, Accidental fall into storm drain or manhole
E884.0, Fall from playground equipment
E884.1, Fall from cliff
E885.0, Fall from (nonmotorized) scooter
E885.1, Fall from roller skates
E885.2, Fall from skateboard
E885.3, Fall from skis
E885.4, Fall from snowboard
E886.0, Fall on same level from collision, pushing, or shoving, by or with other person, In sports
E890.0-E89.9, Conflagration in private dwelling
E893.0, Accident caused by ignition of clothing, from controlled fire in private dwelling
E893.2, Accident caused by ignition of clothing, from controlled fire not in building or structure
E894, Ignition of highly inflammable material
E895, Accident caused by controlled fire in private dwelling
E897, Accident caused by controlled fire not in building or structure
E898.0-E898.1, Accident caused by other specified fire and flames
E917.0, Striking against or struck accidentally by objects or persons, in sports without subsequent fall
E917.1, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic without subsequent fall
E917.2, Striking against or struck accidentally by objects or persons, in running water without subsequent fall
E917.5, Striking against or struck accidentally by objects or persons, object in sports with subsequent fall
E917.6, Striking against or struck accidentally by objects or persons, caused by a crowd, by collective fear or panic with subsequent fall
E919, Accidents caused by machinery
E921.0-E921.9, Accident caused by explosion of pressure vessel
E922.0-E922.9, Accident caused by firearm and air gun missile
E924.1, Caustic and corrosive substances
E926.2, Visible and ultraviolet light sources
E927, Overexertion and strenuous movements
E928.0-E928.8, Other and unspecified environmental and accidental causes
E929.0-E929.9, Late effects of accidental injury
E959, Late effects of self-inflicted injury
E970-E978, Legal intervention
E979, Terrorism
E981.0-E980.9, Poisoning by gases in domestic use, undetermined whether accidentally or purposely inflicted

E982.0-E982.9, Poisoning by other gases, undetermined whether accidentally or purposely inflicted
E985.0-E985.7, Injury by firearms, air guns and explosives, undetermined whether accidentally or purposely inflicted
E987.0, Falling from high place, undetermined whether accidentally or purposely inflicted, residential premises
E987.2, Falling from high place, undetermined whether accidentally or purposely inflicted, natural sites
E989, Late effects of injury, undetermined whether accidentally or purposely inflicted
E990-E999, Injury resulting from operations of war

POA Examples

General Medical Surgical

1. Patient is admitted for diagnostic work-up for cachexia. The final diagnosis is malignant neoplasm of lung with metastasis.

   Assign "Y" on the POA field for the malignant neoplasm.. The malignant neoplasm was clearly present on admission, although it was not diagnosed until after the admission occurred.

2. A patient undergoes outpatient surgery. During the recovery period, the patient develops atrial fibrillation and the patient is subsequently admitted to the hospital as an inpatient.

   Assign "Y" on the POA field for the atrial fibrillation since it developed prior to a written order for inpatient admission.

3. A patient is treated in observation and while in Observation, the patient falls out of bed and breaks a hip. The patient is subsequently admitted as an inpatient to treat the hip fracture.

   Assign "Y" on the POA field for the hip fracture since it developed prior to a written order for inpatient admission.

4. A patient with known congestive heart failure is admitted to the hospital after he develops decompensated congestive heart failure.

   Assign "Y" on the POA field for the congestive heart failure. The ICD-9-CM code identifies the chronic condition and does not specify the acute exacerbation.

5. A patient undergoes inpatient surgery. After surgery, the patient develops fever and is treated aggressively. The physician's final diagnosis documents "possible postoperative infection following surgery."

   Assign "N" on the POA field for the postoperative infection since final diagnoses that contain the terms "possible", "probable", "suspected" or "rule out" and that are based on symptoms or clinical findings that were not present on admission should be reported as "N".

6. A patient with severe cough and difficulty breathing was diagnosed during his hospitalization to have lung cancer.

   Assign "Y" on the POA field for the lung cancer. Even though the cancer was not diagnosed until after admission, it is a chronic condition that was clearly present before the patient's admission.

7. A patient is admitted to the hospital for a coronary artery bypass surgery. Postoperatively he developed a pulmonary embolism.

   Assign "N" on the POA field for the pulmonary embolism. This is an acute condition that was not present on admission.

8. A patient is admitted with a known history of coronary atherosclerosis, status post myocardial infarction five years ago is now admitted for treatment of impending myocardial infarction. The final diagnosis is documented as "impending myocardial infarction."

   Assign "Y" to the impending myocardial infarction because the condition is present on admission.

9. A patient with diabetes mellitus developed uncontrolled diabetes on day 3 of the hospitalization.

   Assign "N" to the diabetes code because the "uncontrolled" component of the code was not present on admission.

10. A patient is admitted with high fever and pneumonia. The patient rapidly deteriorates and becomes septic. The discharge diagnosis lists sepsis and pneumonia. The documentation is unclear as to whether the sepsis was present on admission or developed shortly after admission.

   Query the physician as to whether the sepsis was present on admission, developed shortly after admission, or it cannot be clinically determined as to whether it was present on admission or not.

11. A patient is admitted for repair of an abdominal aneurysm. However, the aneurysm ruptures after hospital admission.

   Assign "N" for the ruptured abdominal aneurysm. Although the aneurysm was present on admission, the "ruptured" component of the code description did not occur until after admission.

12. A patient with viral hepatitis B progresses to hepatic coma after admission.

   Assign "N" for the viral hepatitis B with hepatic coma because part of the code description did not develop until after admission.

13. A patient with a history of varicose veins and ulceration of the left lower extremity strikes the area against the side of his hospital bed during an inpatient hospitalization. It bleeds profusely. The final diagnosis lists varicose veins with ulcer and hemorrhage.

Assign "Y" for the varicose veins with ulcer. Although the hemorrhage occurred after admission, the code description for varicose veins with ulcer does not mention hemorrhage.

Obstetrics

1. A female patient was admitted to the hospital and underwent a normal delivery.

   Leave the "present on admission" (POA) field blank. Code 650, Normal delivery, is on the "exempt from reporting" list.

2. Patient admitted in late pregnancy due to excessive vomiting and dehydration. During admission patient goes into premature labor

   Assign "Y" for the excessive vomiting and the dehydration.
   Assign "N" for the premature labor

3. Patient admitted in active labor. During the stay, a breast abscess is noted when mother attempted to breast feed. Provider is unable to determine whether the abscess was present on admission

   Assign "W" for the breast abscess.

4. Patient admitted in active labor. After 12 hours of labor it is noted that the infant is in fetal distress and a Cesarean section is performed

   Assign "N" for the fetal distress.

Newborn

1. A single liveborn infant was delivered in the hospital via Cesarean section. The physician documented fetal bradycardia during labor in the final diagnosis in the newborn record.

   Assign " Y" because the bradycardia developed prior to the newborn admission (birth).

2. A newborn developed diarrhea which was believed to be due to the hospital baby formula.

   Assign " N" because the diarrhea developed after admission.